

AMENDED IN ASSEMBLY MAY 2, 2006

AMENDED IN ASSEMBLY APRIL 6, 2006

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL

No. 2889

Introduced by Assembly Member Frommer

February 24, 2006

An act to amend Section 1366.35 of the Health and Safety Code, and to amend Section 10785 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2889, as amended, Frommer. Health care coverage: federally eligible defined individual.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are prohibited from declining to cover or enroll a federally eligible defined individual, except as specified, and are also prohibited from imposing a preexisting condition exclusion with respect to such a person. Existing law defines a federally eligible defined individual, in part, as an individual who has had 18 months of creditable coverage, with the most recent coverage being under a group plan or specified governmental or church plan.

This bill would expand the definition of a federally eligible defined individual to include an individual who has had 18 months of

creditable coverage, with the most recent coverage being under an individual health plan, as specified.

Because the bill, by expanding this definition, would prohibit a plan from denying coverage or enrollment to a larger group of persons, it would make additional conduct unlawful under the Knox-Keene Act, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1366.35 of the Health and Safety Code
2 is amended to read:

3 1366.35. (a) A health care service plan providing coverage
4 for hospital, medical, or surgical benefits under an individual
5 health care service plan contract may not, with respect to a
6 federally eligible defined individual desiring to enroll in
7 individual health insurance coverage, decline to offer coverage
8 to, or deny enrollment of, the individual or impose any
9 preexisting condition exclusion with respect to the coverage.

10 (b) For purposes of this section, “federally eligible defined
11 individual” means an individual who, as of the date on which the
12 individual seeks coverage under this section, meets all of the
13 following conditions:

14 (1) Has had 18 or more months of creditable coverage, and
15 whose most recent prior creditable coverage was under a group
16 or individual health plan, a federal governmental plan maintained
17 for federal employees, or a governmental plan or church plan as
18 defined in the federal Employee Retirement Income Security Act
19 of 1974 (29 U.S.C. Sec. 1002). For the purposes of this
20 paragraph, an individual health plan shall not include vision only,
21 dental only, accident only, specified disease, hospital indemnity,
22 Medicare supplement, CHAMPUS supplement, long-term care, a
23 contract or arrangement that provides access to discounted or

1 *reduced rates for health care services or providers but the*
2 *individual retains responsibility for full payment of the*
3 *discounted rates, or disability income insurance.*

4 (2) Is not eligible for coverage under a group health plan,
5 Medicare, or Medi-Cal, and does not have other health insurance
6 coverage.

7 (3) Was not terminated from his or her most recent creditable
8 coverage due to nonpayment of premiums or fraud.

9 (4) If offered continuation coverage under COBRA or
10 Cal-COBRA, has elected and exhausted that coverage.

11 (c) Every health care service plan shall comply with applicable
12 federal statutes and regulations regarding the provision of
13 coverage to federally eligible defined individuals, including any
14 relevant application periods.

15 (d) A health care service plan shall offer the following health
16 benefit plan contracts under this section that are designed for,
17 made generally available to, are actively marketed to, and enroll,
18 individuals: (1) either the two most popular products as defined
19 in Section 300gg-41(c)(2) of Title 42 of the United States Code
20 and Section 148.120(c)(2) of Title 45 of the Code of Federal
21 Regulations or (2) the two most representative products as
22 defined in Section 300gg-41(c)(3) of the United States Code and
23 Section 148.120(c)(3) of Title 45 of the Code of Federal
24 Regulations, as determined by the plan in compliance with
25 federal law. A health care service plan that offers only one health
26 benefit plan contract to individuals, excluding health benefit
27 plans offered to Medi-Cal or Medicare beneficiaries, shall be
28 deemed to be in compliance with this article if it offers that
29 health benefit plan contract to federally eligible defined
30 individuals in a manner consistent with this article.

31 (e) (1) In the case of a health care service plan that offers
32 health insurance coverage in the individual market through a
33 network plan, the plan may do both of the following:

34 (A) Limit the individuals who may be enrolled under that
35 coverage to those who live, reside, or work within the service
36 area for the network plan.

37 (B) Within the service area of the plan, deny coverage to
38 individuals if the plan has demonstrated to the director that the
39 plan will not have the capacity to deliver services adequately to
40 additional individual enrollees because of its obligations to

1 existing group contractholders and enrollees and individual
2 enrollees, and that the plan is applying this paragraph uniformly
3 to individuals without regard to any health status-related factor of
4 the individuals and without regard to whether the individuals are
5 federally eligible defined individuals.

6 (2) A health care service plan, upon denying health insurance
7 coverage in any service area in accordance with subparagraph
8 (B) of paragraph (1), may not offer coverage in the individual
9 market within that service area for a period of 180 days after the
10 coverage is denied.

11 (f) (1) A health care service plan may deny health insurance
12 coverage in the individual market to a federally eligible defined
13 individual if the plan has demonstrated to the director both of the
14 following:

15 (A) The plan does not have the financial reserves necessary to
16 underwrite additional coverage.

17 (B) The plan is applying this subdivision uniformly to all
18 individuals in the individual market and without regard to any
19 health status-related factor of the individuals and without regard
20 to whether the individuals are federally eligible *defined*
21 individuals.

22 (2) A health care service plan, upon denying individual health
23 insurance coverage in any service area in accordance with
24 paragraph (1), may not offer that coverage in the individual
25 market within that service area for a period of 180 days after the
26 date the coverage is denied or until the issuer has demonstrated to
27 the director that the plan has sufficient financial reserves to
28 underwrite additional coverage, whichever is later.

29 (g) The requirement pursuant to federal law to furnish a
30 certificate of creditable coverage shall apply to health insurance
31 coverage offered by a health care service plan in the individual
32 market in the same manner as it applies to a health care service
33 plan in connection with a group health benefit plan.

34 (h) A health care service plan shall compensate a life agent or
35 fire and casualty broker-agent whose activities result in the
36 enrollment of federally eligible defined individuals in the same
37 manner and consistent with the renewal commission amounts as
38 the plan compensates life agents or fire and casualty
39 broker-agents for other enrollees who are not federally eligible

1 defined individuals and who are purchasing the same individual
2 health benefit plan contract.

3 (i) Every health care service plan shall disclose as part of its
4 COBRA or Cal-COBRA disclosure and enrollment documents,
5 an explanation of the availability of guaranteed access to
6 coverage under the Health Insurance Portability and
7 Accountability Act of 1996, including the necessity to enroll in
8 and exhaust COBRA or Cal-COBRA benefits in order to become
9 a federally eligible defined individual.

10 (j) No health care service plan may request documentation as
11 to whether or not a person is a federally eligible defined
12 individual other than is permitted under applicable federal law or
13 regulations.

14 (k) This section shall not apply to coverage defined as
15 excepted benefits pursuant to Section 300gg(c) of Title 42 of the
16 United States Code.

17 (l) This section shall apply to health care service plan contracts
18 offered, delivered, amended, or renewed on or after January 1,
19 2001.

20 SEC. 2. Section 10785 of the Insurance Code is amended to
21 read:

22 10785. (a) A health insurer that covers hospital, medical, or
23 surgical expenses under an individual health benefit plan as
24 defined in subdivision (a) of Section 10198.6 may not, with
25 respect to a federally eligible defined individual desiring to enroll
26 in individual health insurance coverage, decline to offer coverage
27 to, or deny enrollment of, the individual or impose any
28 preexisting condition exclusion with respect to the coverage.

29 (b) For purposes of this section, "federally eligible defined
30 individual" means an individual who, as of the date on which the
31 individual seeks coverage under this section, meets all of the
32 following conditions:

33 (1) Has had 18 or more months of creditable coverage, and
34 whose most recent prior creditable coverage was under a group
35 or individual health plan, a federal governmental plan maintained
36 for federal employees, or a governmental plan or church plan as
37 defined in the federal Employee Retirement Income Security Act
38 of 1974 (29 U.S.C. Sec. 1002). For the purposes of this
39 paragraph, an individual health plan shall not include vision only,
40 dental only, accident only, specified disease, hospital indemnity,

1 Medicare supplement, CHAMPUS supplement, long-term care, a
2 contract or arrangement that provides access to discounted or
3 reduced rates for health care services or providers but the
4 individual retains responsibility for full payment of the
5 discounted rates, or disability income insurance.

6 (2) Is not eligible for coverage under a group health plan,
7 Medicare, or Medi-Cal, and does not have other health insurance
8 coverage.

9 (3) Was not terminated from his or her most recent creditable
10 coverage due to nonpayment of premiums or fraud.

11 (4) If offered continuation coverage under COBRA or
12 Cal-COBRA, has elected and exhausted that coverage.

13 (c) Every health insurer that covers hospital, medical, or
14 surgical expenses shall comply with applicable federal statutes
15 and regulations regarding the provision of coverage to federally
16 eligible defined individuals, including any relevant application
17 periods.

18 (d) A health insurer shall offer the following health benefit
19 plans under this section that are designed for, made generally
20 available to, are actively marketed to, and enroll, individuals:
21 (1) either the two most popular products as defined in Section
22 300gg-41(c)(2) of Title 42 of the United States Code and Section
23 148.120(c)(2) of Title 45 of the Code of Federal Regulations or
24 (2) the two most representative products as defined in Section
25 300gg-41(c)(3) of the United States Code and Section
26 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
27 determined by the insurer in compliance with federal law. An
28 insurer that offers only one health benefit plan to individuals,
29 excluding health benefit plans offered to Medi-Cal or Medicare
30 beneficiaries, shall be deemed to be in compliance with this
31 chapter if it offers that health benefit plan contract to federally
32 eligible defined individuals in a manner consistent with this
33 chapter.

34 (e) (1) In the case of a health insurer that offers health benefit
35 plans in the individual market through a network plan, the insurer
36 may do both of the following:

37 (A) Limit the individuals who may be enrolled under that
38 coverage to those who live, reside, or work within the service
39 area for the network plan.

1 (B) Within the service area covered by the health benefit plan,
2 deny coverage to individuals if the insurer has demonstrated to
3 the commissioner that the insured will not have the capacity to
4 deliver services adequately to additional individual insureds
5 because of its obligations to existing group policyholders, group
6 contractholders and insureds, and individual insureds, and that
7 the insurer is applying this paragraph uniformly to individuals
8 without regard to any health status-related factor of the
9 individuals and without regard to whether the individuals are
10 federally eligible defined individuals.

11 (2) A health insurer, upon denying health insurance coverage
12 in any service area in accordance with subparagraph (B) of
13 paragraph (1), may not offer health benefit plans through a
14 network in the individual market within that service area for a
15 period of 180 days after the coverage is denied.

16 (f) (1) A health insurer may deny health insurance coverage in
17 the individual market to a federally eligible defined individual if
18 the insurer has demonstrated to the commissioner both of the
19 following:

20 (A) The insurer does not have the financial reserves necessary
21 to underwrite additional coverage.

22 (B) The insurer is applying this subdivision uniformly to all
23 individuals in the individual market and without regard to any
24 health status-related factor of the individuals and without regard
25 to whether the individuals are federally eligible defined
26 individuals.

27 (2) A health insurer, upon denying individual health insurance
28 coverage in any service area in accordance with paragraph (1),
29 may not offer that coverage in the individual market within that
30 service area for a period of 180 days after the date the coverage is
31 denied or until the insurer has demonstrated to the commissioner
32 that the insurer has sufficient financial reserves to underwrite
33 additional coverage, whichever is later.

34 (g) The requirement pursuant to federal law to furnish a
35 certificate of creditable coverage shall apply to health-benefits
36 *benefit* plans offered by a health insurer in the individual market
37 in the same manner as it applies to an insurer in connection with
38 a group health benefit plan policy or group health benefit plan
39 contract.

(h) A health insurer shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every health insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No health insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(l) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

CORRECTIONS:

Text - Page 4.

O